

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07366

CERTIFICATE OF DEATH

07340

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 337 - 17th Place, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) FRED		First NMT	Middle BABB	Last July	Month 18	Day Year 1957
4. DATE OF DEATH	Month	Day	Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1893	9. AGE (In years last birthday) 63	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY GSA-US Government		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Steve Baboy			14. MOTHER'S MAIDEN NAME Irene Baboy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Unknown Hospital Records, VA Hospital, Perry Point, Md.		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved						INTERVAL BETWEEN ONSET AND DEATH 1 - 2 days
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 420.0						
(b) Fibrosis of the myocardium due to degeneration and replacement fibrosis						unknown
(c) Arteriosclerotic heart disease						unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X Arteriosclerosis general, moderately severe - unknown						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 3, 1957 , to July 18, 1957 , and that death occurred at 3:10 P.M. , from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) VAH, Perry Point, Md.						
DATE SIGNED 7-22-57						
ACTUAL SIGNATURE <i>W. Oppler</i>						
PHYSICIAN'S NAME (Type) W. OPPLER						
Director, Professional Services						
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Perry Point & Son</i>						
ADDRESS Havre DeGrace, Md.						
24a. REC'D BY REGISTRAR DATE 7-23-57						
24b. REGISTRAR'S SIGNATURE <i>Jane E. Daugherty</i>						

BY JAMES MURRAY - KETTLEMAN CITY, TEXAS - 1931 - 35 X 22 INCHES

BUREAU V.

July 25 1957

РЕГЕЛИЯ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07341

7367

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 8yrs. 7mo. 3days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
3. NAME OF DECEASED (Type or print) HARRISON		First Middle Last C. CADWALLADER	4. DATE OF DEATH July 25 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-4-10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal	9. AGE (in years last birthday) 47 yrs.
		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edgar Cadwallader		14. MOTHER'S MAIDEN NAME Helen King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II	17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Epilepticus, cause unknown 353.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. s. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 22, 1948, to July 25, 1957, and that death occurred at 3:20 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. V.A. Hospital, Perry Point, Md. DATE SIGNED 7-26-57			
ACTUAL SIGNATURE W. Oppler		Director, Professional Services	
PHYSICIAN'S NAME (Type) W. OPPLER		22. BURIAL, CREMATION, REMOVAL 7-26-57	
22b. DATE THEREOF 7-26-57		22c. NAME OF CEMETERY OR CREMATORIAL Parkwood	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, North & Penna. Ave.,		24a. REC'D BY REGISTRAR 7-26-57 Irene E. Daugherty	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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BUREAU Y. S.

JUL 30 1957

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07342
96

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

6
C 7368

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Washington		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 24 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. 47x-3				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 5102 5th St., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Samuel Carpenter		First	Middle	Last	4. DATE OF DEATH July 29,	Month	Day	Year 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-19-91	9. AGE (in years last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Carpenter				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hosp. Records, VAH, Perry Point, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 923.7		Strangulation				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) foreign body in larynx				10 minutes		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Foreign body in larynx						
20c. TIME OF INJURY Hour 20c 5.04 p. m.		Month, Day, Year 7-29-57 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA Hospital	20f. (City or town) Perry Point, Maryland (Cecil)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>R. C. Dodson</i>		DATE SIGNED 7-30-57						
EXAMINER'S NAME (Type) R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 1-57	22c. NAME OF CEMETERY OR CREMATORIAL Potowmack		22d. LOCATION (City, town, or county) Laymon, Virginia			(State)
23. FUNERAL DIRECTOR'S SIGNATURE NASH & SLAW FUNERAL HOME, NINDE, VIRGINIA		ADDRESS		24a. REC'D BY REGISTRAR DATE 7-30-57		24b. REGISTRAR'S SIGNATURE Dene E. Langford		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE GOVERNMENT OF
MEDICAL EXAMINER-CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.

JUG 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07343

7369

CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. V.O. 1-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 15 E. Fort Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BERNARD	Middle	Last COHEN	4. DATE OF DEATH July	Month	Day 30	Year 19 57
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-22	9. AGE (In years last birthday) 35 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Cleaning		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hyman Cohen				14. MOTHER'S MAIDEN NAME Rebecca Lahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. PL28		17. INFORMANT Unknown		Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia due to</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Pyelo Nephritis</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 10 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. <u>19</u> p. m.	Month 19	Day 19	Year 1957	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rosedale	20f. (City or town) Baltimore	(County) (State) Baltimore, Maryland
21. I certify that I attended the deceased from <u>7-8-57</u> , 19 57, to <u>7-30</u> , 19 57, and that death occurred at <u>1:20P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) M.D.							
ACTUAL SIGNATURE <u>W. Oppeler</u>							
PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Director, Professional Services, VAH, Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7-30-57	22c. NAME OF CEMETERY OR CREMATORIAL Rosedale	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE JACK LEWIS, Inc. Funeral Home, Baltimore, Md.				ADDRESS 24a. REC'D BY REGISTRAR DATE 7-30-57 24b. REGISTRAR'S SIGNATURE Irene E. Daugherty			

CHIEF INSPECTOR OF DEATH

CHIEF INSPECTOR OF DEATH

CHIEF INSPECTOR OF DEATH

BUREAU Y. S

JUL 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07345

Reg. Dist. No. 94

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1		67370		00	
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
Cecil		b. STATE N.Y.		b. COUNTY Kings	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓	
North East, R.D.		—		Brooklyn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		255 Union Ave.	
3. NAME OF DECEASED (Type or print)		First John	Middle Comitini	4. DATE OF DEATH	Month 7 Day 28 Year 19 57
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-1896	9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Doll Stubber		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Frank Comitini		14. MOTHER'S MAIDEN NAME Mary Bruno		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 064-07-0070		17. INFORMANT Address Brooklyn, N.Y. Angelina Manduca, 1125, Forty first St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816 X		Crushed chestn Partial amputation right foot Fracr			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Fracture of left femur right forearm and			
DUE TO (c)		Laceration of right side of face.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMAR ^Y or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car pulled across grass plot in front of Bus			
20c. TIME OF INJURY Month, Day, Year 3:35 a.m. 7-28-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40	
20f. (City or town) North East				(County) Cecil	
				(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>R.C. Dodson</i>		DATE SIGNED 7-29-57			
EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF July 29-1957		22c. NAME OF CEMETERY OR CREMATORIUM St. Raymond	
22d. LOCATION (City, town, or county) Bronx New York City		(State) N.Y.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Haas North East Maryland</i>		24a. REC'D BY REGISTRAR DATE 7-29-57			
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Sarah E. Rothermel</i>			

MEDICAL EXAMINER - CERTIFICATE OF DEATH

RECEIVED
BUREAU X-8
July 13 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07346

07371

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 1mo. 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. V 01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 3515 Spaulding Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ALBERT		First I.	Middle DUBECK	4. DATE OF DEATH July	Month 13	Day 1957	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 12, 1911	9. AGE (In years last birthday) 46 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY US Post Office		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PHILIP DUBECK		14. MOTHER'S MAIDEN NAME ANNA SISCO		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-II		17. INFORMANT Hospital Records, VAH., Perry Point, Md.		INTERVAL BETWEEN ONSET AND DEATH 4 to 6 hrs.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema and Congestion, bilateral, severe</u> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Lymphosarcoma, Gastro-Intestinal Tract and Retro-</u> DUE TO <u>peritoneal Lymph Nodes.</u> Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.1 <u>Atherosclerosis, Coronary Arteries, severe.</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County)	(State)	
21. I certify that <u>JA</u> attended the deceased from <u>May 14, 1957</u> to <u>July 13, 1957</u> and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William M. Harris</u> M.D.							
PHYSICIAN'S NAME (Type) WILLIAM M. HARRIS, M. D., Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-14-57		22c. NAME OF CEMETERY OR CREMATORIAL Bnai Israel Congregation		22d. LOCATION (City, town, or county) Baltimore, Maryland, (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JACK LEWIS INC.</u>		ADDRESS 2100 Eutaw Place, BALTIMORE 17, MD.		24a. REC'D BY REGISTRAR DENA E. DUGAN		24b. REGISTRAR'S SIGNATURE DATE 7-14-57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07347

07352

CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

Cecil

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Elkton

c. LENGTH OF STAY IN lb

3 Days

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Union Hospital

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Liberty Grove x2

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATHJuly
Month19
Day1957
Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Nov. 1 1868

9. AGE (in years
last birthday)
yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Retired School Teacher Public schools Liberty Grove Md. U.S.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Theodore Graham Elga Caldwell

Address 32 St. Paul St.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

No

None

Robert White

Baltimore Md.

INTERVAL BETWEEN
ONSET AND DEATH.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Bronchopneumonia

491X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

422.1 Arteriosclerotic cardiovascular disease

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o.m.
p.m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from July 17, 1957, to July 19, 1957, that I last saw the deceased alive on July 19, 1957, and that death occurred at 10:45 p.m. from the causes and on the date stated above.

ACTUAL
SIGNATURE

Ralph Andrews Jr., M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

233 E. Main St., Elkton, Md. 7/19/57

PHYSICIAN'S
NAME (Type)

S. Ralph Andrews, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIAL

22d. LOCATION (City, town, or county)

(State)

Burial July 23/57 West Nottingham Colored Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D. BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07348

07353 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 92

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information, prior to burial or removal.

M
C
65
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1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 Hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. STREET ADDRESS R.D. 3	
3. NAME OF DECEASED (Type or print) Roger		First Lee	Middle Graham
4. DATE OF DEATH 7	Month 7	Day 15	Year 1957
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1957
9. AGE (In years last birthday) 4 yrs.		10. UNDER 1 YEAR Months 4 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lee Graham		14. MOTHER'S MAIDEN NAME Eloise Muncy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Lee Graham, Elkton, R.D. 3 Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson		DATE SIGNED 7-15-57	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/57	
22c. NAME OF CEMETERY OR CREMATORIAL Bog Creek		22d. LOCATION (City, town, or county) Dr. Wm. West, Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. Harry Pappas		ADDRESS Elkton, Md.	
24a. REC'D. BY REGISTRAR DATE 7/18/57		24b. REGISTRAR'S SIGNATURE T. F. Frazer	

BY THE STATE ATTORNEY GENERAL - CALIFORNIA
HONORABLE EXAMINER'S OFFICE

BUREAU V. S

JUL 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07349
7-11-57

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		d. STREET ADDRESS 1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Joseph		First	Middle	Last	4. DATE OF DEATH 7 10 1957	Month	Day	Year
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-1867	9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY nothing		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Hamilton		14. MOTHER'S MAIDEN NAME Susan Riale		Address Ernest Hamilton, North East, Md.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No								
16. SOCIAL SECURITY NO. 491X								
17. INFORMANT Fracture of right femur								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of right femur DUE TO 903.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral Broncho Pneumonia DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 6-12-57		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell walking down the street.						
20c. TIME OF INJURY Month, Day, Year Hour 6.35 a.m.		20d. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) Street		20f. (City or town) North East		(County) Cecil		(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accidental <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE R. C. Dodson		DATE SIGNED 7-11-57						
EXAMINER'S NAME (Type) R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 13, 1957		22b. DATE THEREOF July 13, 1957		22c. NAME OF CEMETERY OR CREMATORIAL West Gillingham Cem.		22d. LOCATION (City, town, or county) (State) Colona, Cecil Md.		
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson		ADDRESS 1 Rising Sun Rd.		24a. REC'D BY REGISTRAR J. P. Loyer		24b. REGISTRAR'S SIGNATURE J. P. Loyer		
VS. A15ME(S) SM 9/55								

81 21001162 4623190 0100740000 STATE GRANTVILLE
HTA0000 STADT0002 21001162 1021000

BUREAU V. S.

July 25 1957

RECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film C218 7-30-57 et

07350
92

07355

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		b. COUNTY Cecil	
c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Rural - Elkton R. D. 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First REBA	Middle E.	Last HAMILTON
4. DATE OF DEATH	Month July	Day 15	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1874
9. AGE (In years lost birthday) 83 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry McConnell		14. MOTHER'S MAIDEN NAME Margaret Barclay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ----- Hospital Records	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH May 9, 1957			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 12, 1957, to July 15, 1957, that I last saw the deceased alive on July 15, 1957, and that death occurred at 4:28 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 135 West Main Street DATE SIGNED			
ACTUAL SIGNATURE <u>Dr. Milford H. Sprecher</u> M.D.			
PHYSICIAN'S NAME (Type) Milford H. Sprecher, M.D. Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Sharps Cemetery		22d. LOCATION (City, town, or county) Cecil County Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>		ADDRESS Elkton, Maryland	
24a. REC'D BY REGISTRAR DATE 7/18/57		24b. REGISTRAR'S SIGNATURE <u>FR Frazer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07356

CERTIFICATE OF DEATH

Reg. Dist. No. 92

07351

1. PLACE OF DEATH a. COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS <i>18 Walter Boulden St.</i>			
e. LENGTH OF STAY IN lb <i>15 yrs</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Henry</i>	Last <i>Harris</i>		
4. DATE OF DEATH <i>July 12</i>	Month <i>July</i>	Day <i>12</i>	Year <i>1957</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>wh</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 2 1874</i>		
9. AGE (In years last birthday) <i>83</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former farm owner</i>	11. BIRTHPLACE (State or foreign country) <i>Golts, Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>V.S.A.</i>		
13. FATHER'S NAME <i>Hansen Harris</i>	14. MOTHER'S MAIDEN NAME <i>Rebecca Lewis</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>215 329 281</i>		17. INFORMANT <i>Mrs. Joss Anthony</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>592X</i> (b) <i>CHRONIC NEPHRITIS</i> DUE TO (c)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Chesapeake City, Md</i>	20f. (City or town) <i>Chesapeake City, Md</i>	(County) <i>Chesapeake City, Md</i>	(State) <i>Chesapeake City, Md</i>
21. I certify that I attended the deceased from <i>July 12</i> , 1957, to <i>July 12</i> , 1957, that I last saw the deceased alive on <i>July 12</i> , 1957, and that death occurred at <i>Chesapeake City, Md</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Chesapeake City, Md</i>					
ACTUAL SIGNATURE <i>Henry V. Davis</i>	DATE SIGNED <i>7/15/57</i>				
PHYSICIAN'S NAME (Type) <i>Henry V. Davis MD</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>July 14/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel</i>	22d. LOCATION (City, town, or county) <i>Chesapeake City, Md</i>	(State) <i>Chesapeake City, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Pippin</i>	ADDRESS <i>Elkton, Md</i>	24a. REC'D BY REGISTRAR DATE <i>7/15/57</i>	24b. REGISTRAR'S SIGNATURE <i>DR Frazer</i>		

7372

07352

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 181

1. PLACE OF DEATH: COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Delaware</u> COUNTY <u>Wilmington</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rural</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Aberdeen Proving Ground, Del.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ames</u>		STREET ADDRESS <u>12x02</u>	
3. NAME OF DECEASED: (First) <u>Amos</u> (Middle) <u>Hickman</u> (Last)		4. DATE OF DEATH <u>Aug. 20</u> 1957	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH <u>7 Dec. 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Army</u>	11. BIRTHPLACE (State or foreign country): <u>Wilmington, Del</u>
13. FATHER'S NAME: <u>William Hickman</u>		14. MOTHER'S MAIDEN NAME: <u>Ida Boyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>Current</u>		16. SOCIAL SECURITY NO.: <u>161-91-0000</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Ida Miller 221 King Street, Wilmington, Del.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>Immediate cause (a) Due to</u> <u>Antecedent cause(s) (b) Due to</u> <u>Diseases or conditions, if any, giving rise to the above cause (c) Due to</u> <u>stating underlying cause last</u>		INTERVAL BETWEEN ONSET AND DEATH <u>0 days</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture of cervical spine -</u>		19. DATE OF OPERATION: <u>Aug. 20, 1957</u>	
19a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Highway</u>)	21c. (City or town) <u>Delaware</u> (County) <u>Delaware</u> (State) <u>Delaware</u>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Aug. 20, 1957 6:45 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Auto collision</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> SIGNATURE <u>Donald H. Spence</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>7/22/57</u>	NAME OF CEMETERY OR CREMATORIUM <u>Wilmington Cemetery</u> LOCATION (City, town, or county) <u>Wilmington, Delaware</u> (State)
DATE REC'D BY LOCAL REG. <u>July 23-1957</u>		REGISTRAR'S SIGNATURE <u>Wm. R. Ferry</u>	24. FUNERAL DIRECTOR <u>John G. Tarrington Aberdeen, Md.</u> ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADED INK. Supply every item of information carefully. The correct
age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
BUREAU V. S.

JUL 26 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07357 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 92

07353

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 Hour Lazyea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS 117 Bow		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Robert		First F	Middle Holmes	Last E	4. DATE OF DEATH 7	Month 7	Day 1	Year 1957
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1913	9. AGE (In years last birthday) 47 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Town Officer		11. BIRTHPLACE (State or foreign country) Cecil Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Holmes		14. MOTHER'S MAIDEN NAME Annie McDonald						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-013543		17. INFORMANT Howard Holmes, Elkton, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Penetrating 38 Caliber Bullet in the								
976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) frontal bone at hair line in line with nose								
DUE TO into brain tissue (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self with 38 revolver						
20c. TIME OF INJURY Hour 2 p. m.	Month, Day, Year 7-1 1957	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Town office	20f. (City or town) Elkton	(County) Cecil	(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE R. C. Dodson		DATE SIGNED 7-2-57						
EXAMINER'S NAME (Type) R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Rose Bank Cemetery		22d. LOCATION (City, town, or county) (State) Cecil County, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hickey, Elkton, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 7-5-57		24b. REGISTRAR'S SIGNATURE J. F. Frazee		

DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE
OFFICIAL EXAMINERS CERTIFICATE OF DEATH

BUREAU V. S.

JUL 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 219 8-16-57 ams

7373

CERTIFICATE OF DEATH

117354
99

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rainbridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Bainbridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNTC, Bainbridge, Maryland		d. STREET ADDRESS / Dental School, USNTC,	
3. NAME OF DECEASED (Type or print) First William		Last Middle Arthur Holthusen	
4. DATE OF DEATH July 4 19 57		Month July	Day 4 Year 19 57
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-16-39	
9. AGE (In years lost birthday) 18 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Illinois	
10c. BIRTHPLACE (State or foreign country) Illinois		11. MOTHER'S MAIDEN NAME Unknown	
13. FATHER'S NAME Oscar Holthusen		14. INFORMANT Navy Records	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1956 - 1957 549 50 2628	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 795.2 Conditions, if any, which gave rise to immediate cause (a), slothing the under- lying cause lost. } DUE TO (b) Acute Physiological Alteration - Type Unknown Immediate	
DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 4, 1957, to July 4, 1957, that I last saw the deceased alive on D.O.A. July 4, 1957, and that death occurred at 1:17 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE D. H. Souilliard M.D. U.S. Naval Hospital DATE SIGNED 7-5-57			
PHYSICIAN'S NAME (Type) D. H. SOUILLIARD LT, MC, USNR		Bainbridge, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7-8-57		22b. DATE THEREOF 7-8-57	
22c. NAME OF CEMETERY OR CREMATORIUM LOCKPORT CITY CEMETERY		22d. LOCATION (City, town, or county) (State) WILL COUNTY, ILLINOIS	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Patterson, Perryville, Md.		24a. REC'D BY REGISTRAR DATE 7-5-57	
		24b. REGISTRAR'S SIGNATURE Dorothy B. Bramble	

BUREAU V. S.

July 10 1957

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07358

CERTIFICATE OF DEATH

Reg. Dist. No. 07355
792

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. STREET ADDRESS R.D. #2	
3. NAME OF DECEASED (Type or print) Thomas		First Michael	Middle Jackson
4. DATE OF DEATH July	Month July	Day 21	Year 19 57
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Elkton Maryland
13. FATHER'S NAME Arthur Lee Jackson		14. MOTHER'S MAIDEN NAME Bernice Shivery	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Bernice S. Jackson
			Address R.D. #2 Elkton, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.5		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO	
(c)		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-15, 1957, to 7-21, 1957, that I last saw the deceased alive on 7-21, 1957, and that death occurred at 4:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Alphon R. Brooks</i>			ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-28-57	22c. NAME OF CEMETERY OR CREMATORIAL Catholic Cemetery	22d. LOCATION (City, town, or county) Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Henry Pippin</i>		259 E Main St Elkton, Md.	24a. REC'D BY REGISTRAR DATE 7/25/57
		24b. REGISTRAR'S SIGNATURE <i>FB Frazer</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit Permit. Then please remove carbon paper. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

01300M10100—RT1000 30.10.2017 09:10 15472 0941748

BUREAU V. S.

JUL 26 1957

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07356

Reg. Dist. No. 94

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D.		c. LENGTH OF STAY IN 1b -----		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pa.		b. COUNTY Chester	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garden City Chester, Pa. 75X-3		d. STREET ADDRESS 89 Pennsylvania Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First George	Middle Manuel	Last Johnson, Jr.	4. DATE OF DEATH 7 28 1957	Month 7	Day 28	Year 1957
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5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-12-1951	9. AGE (in years last birthday) 6 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY Child	11. BIRTHPLACE (State or foreign country) Chester, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME George Munual Johnson, Sr.	14. MOTHER'S MAIDEN NAME Mae Carol Love
---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 111-12-1234	17. INFORMANT George M. Johnson, 89 Pennsylvania Ave	Address Chester Pa.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowned</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>850X</u>		
DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Thrown from boat by explosion</u>	
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20c. TIME OF INJURY Hour 1-5 p.m.	Month, Day, Year 7 28 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) North East River North East Cecil Md.	(County)	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
---	--	--	--	--	--

ACTUAL SIGNATURE <u>R. G. Dodson</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 7-30-57
--	--	------------------------

EXAMINER'S NAME (Type) R. G. Dodson	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
---	---

22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 7-30-1957	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Joseph R. Grant North East Maryland	22d. LOCATION (City, town, or county) (State) Chester Pa.
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23. FUNERAL DIRECTOR'S SIGNATURE Sarah E. Rothermel	ADDRESS Joseph R. Grant North East Maryland	24a. REC'D BY REGISTRAR DATE 7-30-57	24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel
--	--	---	--

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 1 year.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

WEDIGAT EXAMINER'S CERTIFICATE OF DEATH
STATE OF HAWAII - SALVATION ARMY

BUREAU V. S.

AUG 1 1957

RECEIVED

INSTRUCTIONS**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07357

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Cecil Rising Sun Rural	MARYLAND LENGTH OF STAY (In this place)	STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rising Sun Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS	35 yrs. X0 (If rural give location)		
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Theodora Christine Keppel		July 13 1957	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Married	Aug. 11, 1885.
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
71	Housewife	Philadelphia Pa.	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Theodore Winkler	Mary Ida Cook		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
no		Frank Keppel Rising Sun, Md.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.0 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
18. MEDICAL CERTIFICATION			
INTERVAL BETWEEN ONSET AND DEATH 20 min.			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> el work <input type="checkbox"/> Not while <input type="checkbox"/> el work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 13, 1957</u> , to <u>July 13, 1957</u> , that I last saw the deceased alive on <u>July 13, 1957</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Oscar Taylor</u> ADDRESS (Street, city, town, state) <u>Rising Sun, Md.</u> DATE SIGNED <u>July 15, 1957</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 17, 1957	NAME OF CEMETERY OR CREMATORIAL Asbury
24. REC'D BY REGISTRAR DATE JUL 17 57		REGISTRAR'S SIGNATURE Archaeus	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Earl Tyson, Rising Sun, Md.

DEPARTMENT OF THE SECRETARY OF THE UNITED STATES OF AMERICA

STANFORD UNIVERSITY

STANFORD

01

BUREAU Y.

JUL 17 1957

REGELV ELL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07376

CERTIFICATE OF DEATH

Reg. Dist. No. 07358
96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown		c. LENGTH OF STAY IN 1b Life				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 7		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Charlestown				
3. NAME OF DECEASED (Type or print) Edith		First V	Middle Kreafle			
4. DATE OF DEATH July	Month July	Day 11	Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 2, 1874			
9. AGE (In years last birthday) 83 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Charles	14. MOTHER'S MAIDEN NAME Cooper	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO.		17. INFORMANT Lloyd Cooper, Charlestown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4428 Cardiac Cirrhosis of Liver		INTERVAL BETWEEN ONSET AND DEATH 1 yr.				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Hyper tension Cardio Vascular Renal Disease		DUE TO DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 581.0		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from <u>4 June, 1957</u> to <u>11 July, 1957</u> , that I last saw the deceased alive on <u>10 July, 1957</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.						
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Klaus H. Huchner	ADDRESS (Street, city or town, state) North East Rd			DATE SIGNED 12 July '57		
22a. BURIAL, CREMATION, REMOVAL (Specify). Burial	22b. DATE THEREOF 7-14-1957	22c. NAME OF CEMETERY OR CREMATORIAL Charlestown	22d. LOCATION (City, town, or county) Charlestown, Md.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson, Son	ADDRESS Perryville, Md.	24a. REC'D BY REGISTRAR DATE 7-13-57	24b. REGISTRAR'S SIGNATURE Diane E. Langley			

ІВАНІВСЬКІ – КІДАМ ВО ТВІРЧІСТІ СІРІЯРІАЛІ

July 16 1957

REGELIVEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07359

(7377)

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware		b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 5 mos. 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington		46 X - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 814 West 2nd. Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle 	Last KRIVJANIK	4. DATE OF DEATH July	Month July	Day 28	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2-27-16	9. AGE (In years lost birthday) 41 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 勞工		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Pennsylvania
13. FATHER'S NAME Michael Krivjanik				12. CITIZEN OF WHAT COUNTRY USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. PL 28		17. INFORMANT Hospital Records, VAH, Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease							
082X DUE TO Generalized arteriosclerosis and Cerebral Atrophy unknown							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Encephalitis (Eastern Equine Type) unknown							
DUE TO (c) Encephalitis (Eastern Equine Type) unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.0							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
VA							
21. I certify that I attended the deceased from January 30, 1957 , to July 28, 1957 , X and X saw the deceased X and that death occurred at 11:20 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED 7-29-57							
ACTUAL SIGNATURE h. oppler M.D.							
PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Director, Professional Services, VAH, Perry Point, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1, 57		22c. NAME OF CEMETERY OR CREMATORIUM Silverbrook Cemetery		22d. LOCATION (City, town, or county) Wilmington, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Albert J. McCrory ADDRESS 2400 Bush St. Wilmington, Del. REC'D. BY REGISTRAR JUL 31 1957 REGISTRAR'S SIGNATURE June Daugherty							
McCRORY FUNERAL HOME, 2700 Washington St., Wilm. DEL.							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07260
74

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE N.Y.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East. R.D.		c. LENGTH OF STAY IN lb -----	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York 69X-3	
3. NAME OF DECEASED (Type or print) Robert		First Irving	Middle Lewis
4. DATE OF DEATH 7 24 57		Month 7	Day 28
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 7-24-26
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR 3 months	11. IF UNDER 24 HRS. 3 days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Op.		10b. KIND OF BUSINESS OR INDUSTRY New York City	
11. BIRTHPLACE (State or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Lewis		14. MOTHER'S MAIDEN NAME Anna Singer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.2	17. INFORMANT Albert Lewis, New York City, N.Y.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull and Amputation both legs		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. above Ankles.			
DUE TO (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car went from east lane to west L. and Hit by bus.	
20c. TIME OF INJURY 9:35 a.m. 7 28 57		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 10 North East Cecil Md.
20f. (City or town) North East Cecil		(County) Md.	
(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		DATE SIGNED 7-29-57	
EXAMINER'S NAME (Type) R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) & Removal Reburial		22b. DATE THEREOF 7-29-57	22c. NAME OF CEMETERY OR CREMATORIAL Unknown
22d. LOCATION (City, town, or county) North East, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Brant		24a. REC'D BY REGISTRAR DATE 7-29-57	24b. REGISTRAR'S SIGNATURE Sarah E. Borthwell

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
BUREAU V. S.

JUL 31 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07361

Reg. Dist. No. 96

7379

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 24 yrs. 8 mo. 19 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROY	Middle W.	Last MIDDLECAMP
4. DATE OF DEATH	Month July	Day 20	Year 1957
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-95
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Motion Picture	11. BIRTHPLACE (State or foreign country) West Virginia
13. FATHER'S NAME Arthur Middlecamp		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I	17. INFORMANT Hospital Records, VAH, Perry Point, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease severe		INTERVAL BETWEEN ONSET AND DEATH 4 - 5 days	
DUE TO (c) Arteriosclerosis general severe - unknown		unknown	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491x Arteriosclerosis general severe - unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. VA		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 1, 1952, to July 20, 1957, and that death occurred at 8:30 p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE W. Oppler M.D. VAH, Perry Point, Md.			
DATE SIGNED 7-23-57			
PHYSICIAN'S NAME (Type) W. OPPLER		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 7-23-57	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Hayre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 7-25-57	24b. REGISTRAR'S SIGNATURE Dona E. Daugherty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

01 3904118-07143M 02 793711A 03 7412 05 943 07 08 09 0A 0B 0C 0D 0E 0F 0G 0H 0I 0J 0K 0L 0M 0N 0P 0Q 0R 0S 0T 0U 0V 0W 0X 0Y 0Z

BUREAU V. 8

Jul 26 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07362
92

Reg. Dist. No.

07359

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 North East		d. STREET ADDRESS 1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital. D.O.A.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Louis Etheridge		First	Middle	Last	4. DATE OF DEATH Moore, Jr.	Month	Day	Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 6-30-1943	10. IF UNDER 1 YEAR 14 yrs.	11. IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY Student		11. BIRTHPLACE (State or foreign country) North East. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Louis Etheridge Moore. Sr.		14. MOTHER'S MAIDEN NAME Mildred Lucille Brown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Louis E. Moore. Sr. North East. Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 936.4		Fractured Neck				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO						
		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Hit in the back of the neck and head with baseball						
20c. TIME OF INJURY Hour 7 a.m. 7 9 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ball Diamond		20f. (City or town) (County) (State) North East Cecil Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-10-57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-12-1957		22c. NAME OF CEMETERY OR CREMATORIAL Methodist		22d. LOCATION (City, town, or county) North East Cecil Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East Cecil Md.		24a. REC'D BY REGISTRAR S. J. Frazer		24b. REGISTRAR'S SIGNATURE S. J. Frazer		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU Y. S.

JUL 16 1957

REGISTRATION
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07380

CERTIFICATE OF DEATH

07363
96

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE x2 Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit Rural		c. LENGTH OF STAY IN 1b 18 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1 Port Deposit Rural		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Jacob	Middle Martin	Last Mummert	4. DATE OF DEATH Month July Day 8 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1877	9. AGE (In years from birthday) yrs. months	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. DAYS	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Contracting		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Michael Mummert		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 204-07-683	
17. INFORMANT Mrs. Jacob Mummert		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Chronic DUE TO Hypertension, arteriosclerosis (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 5</u> , 1957, to <u>July 8</u> , 1957, that I last saw the deceased alive on <u>July 7</u> , 1957, and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.		ACTUAL SIGNATURE S. Michael		ADDRESS (Street, city or town, state) M.D.		DATE SIGNED Port Deposit, Md. 2-12-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 11 1957		22c. NAME OF CEMETERY OR CREMATORIAL Pines Cem.		22d. LOCATION (City, town, or county) Newchester (State) Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson Resin, Sun, Md.		ADDRESS		24a. RECEIVED BY REGISTRAR DATE JUL 11 1957		24b. REGISTRAR'S SIGNATURE June Daugherty	

WISCONSIN STATE DEVELOPMENT - SAVINOME 10
CERTIFICATE OF DEATH

BUREAU Y. E.

JUL 11 1957

REGELIV E

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending', in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for reference.

VS. ATSM(E)5
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07360

Reg. Dist. No.

07364
92

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Del.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b -----	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital. D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark	
d. STREET ADDRESS 2 Madison Drive, College Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William		First Robert	Middle Murphy Jr.
3. NAME OF DECEASED (Type or print) William		Lost Murphy Jr.	4. DATE OF DEATH 7 28 1957
S. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24 1918
9. AGE (In years last birthday) 39 yrs.		9. AGE (In years last birthday) 39 yrs.	9. AGE (In years last birthday) 39 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resturer		10b. KIND OF BUSINESS OR INDUSTRY Ice Cream and Food Del.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William R. Murphy, Sr.		14. MOTHER'S MAIDEN NAME Matilda Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II	
17. INFORMANT Wm. R. Murphy, Milford, Del.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull and Left Femur</u> DUE TO 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Car hit Tree		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY 1 hour 20 min. 7 28 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) East Main St. Elkton Cecil Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 7-28-57	
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		22b. DATE THEREOF 7/31/57	
22c. NAME OF CEMETERY OR CREMATORIAL REMOVAL (Specify) Burial		22d. LOCATION (City, town, or county) Odd Fellows Milford Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE William Berry Jr.		24a. REC'D BY REGISTRAR ADDRESS Milford, Del. DATE 8/1/57	
24b. REGISTRAR'S SIGNATURE J. H. Frazer			

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

AUG 5 1957

RECEIVED

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2
B
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G218 8-1-57 et

07361 07365

CERTIFICATE OF DEATH

Reg. Dist. No. 97

1. PLACE OF DEATH a. COUNTY <i>Carroll</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY <i>Cecil</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cecilton</i>	c. LENGTH OF STAY IN 1b <i>1</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>XO Cecilton</i>	d. STREET ADDRESS <i>1</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>THE RESA ANN</i>	First <i>First</i>	Middle <i>Middle</i>	Last <i>OLDHAM</i>
4. DATE OF DEATH <i>July 26</i>	Month <i>July</i>	Day <i>26</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <i>Baby</i>	8. DATE OF BIRTH <i>July 26 1957</i>
9. AGE (In years last birthday) yrs. <i>1</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baby</i>	11. BIRTHPLACE (State or foreign country) <i>Cecilton Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>Cecilton Md.</i>
13. FATHER'S NAME <i>Joseph H. Oldham</i>	14. MOTHER'S MAIDEN NAME <i>Rachel Mason</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT <i>Joseph H. Oldham Cecilton Md.</i>	Address <i>Cecilton Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>770.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	Acute Congestive Failure 70 m.n.		
Erythema blistersis Fetus 7 1/2 hours			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Rh incompatibility, Agenesis of kidney</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>759.3</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 26</i> , 1957, to <i>July 26</i> , 1957, that I last saw the deceased alive on <i>26 July</i> , 1957, and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>Cecilton, Md.</i>	DATE SIGNED <i>28 July 57</i>	
ACTUAL SIGNATURE <i>Wallace Oldham</i>	M.D.		
PHYSICIAN'S NAME (Type)			
22a. BURIAL OR CREMATION, 22b. DATE THEREOF REASON (Specify) <i>Burial July 29 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Salina Cem.</i>	22d. LOCATION (City, town, or county) <i>Salina Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer Yellow Wellington Md.</i>	ADDRESS <i>2065256 XV 9</i>	24a. REC'D BY REGISTRAR DATE <i>JUL 30 1957</i>	24b. REGISTRAR'S SIGNATURE <i>J. R. Flynn</i>

CERTIFICATE OF SERVICE

WILLIAM D. STATE-DEPARTMENT OF JUSTICE-BALTIMORE, MD

BUREAU U. S.

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7362

CERTIFICATE OF DEATH

Reg. Dist. No. 92

07366

1. PLACE OF DEATH a. COUNTY CECIL		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD. b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KAREN LYN PHEASANT		4. DATE OF DEATH July 18 1957	Month Day Year
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 16, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Child	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME CHESTER F. PHEASANT		14. MOTHER'S MAIDEN NAME CAROL ALICE BELDIN	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	17. INFORMANT CHESTER F. PHEASANT
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postnatal aspiration asphyxia and asphyxia 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 40 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — 19 p.m. —	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> not work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 16 July, 1957, to 18 July, 1957, that I last saw the deceased alive on 18 July, 1957, and that death occurred at 405 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Klaus H. Huebner M.D. No. 14 E. 1st. Rd. DATE SIGNED 18 July '57			
ACTUAL SIGNATURE Klaus H. Huebner		PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JULY 20, 1957	22c. NAME OF CEMETERY OR CREMATORIAL CHARLESTOWN	22d. LOCATION (City, town, or county) CHARLESTOWN Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Henry Pappi		ADDRESS Elkton, Md.	24a. REC'D. BY REGISTRAR DATE 7/22/57
			24b. REGISTRAR'S SIGNATURE F. J. Fraser

CERTIFICATE OF DEATH

BUREAU V. S.
JUL 24 1957
RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

117367
92

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.D.3		c. LENGTH OF STAY IN 1b 26 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton R.D.3	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First John	Middle Lillard
4. DATE OF DEATH		Last Reeves	Month 7
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years (last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab, Paper Mill		10b. KIND OF BUSINESS OR INDUSTRY Paper Making	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonah Reeves		14. MOTHER'S MAIDEN NAME Malinda J. Henderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-05-5986A. Ida May Reeves, Elkton, R.D.3 Md. Address	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		22. ACTUAL SIGNATURE R. C. Dodson DATE SIGNED 7-9-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1957	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Union Cemetery Elkton, Md.
22d. LOCATION (City, town, or county) Md.		22d. LOCATION (City, town, or county) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Pepper		24a. REC'D BY REGISTRAR DATE 7/10/57	24b. REGISTRAR'S SIGNATURE F. R. Frazer

BUREAU V. S.
RECEIVED
JUL 12 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07369

7382

CERTIFICATE OF DEATH

Reg. Dist. No. 96

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 should be filed with the funeral director.

1. PLACE OF DEATH a. COUNTY CECIL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 8yrs/17days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum		d. STREET ADDRESS 16 Patapsco	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 16 Patapsco		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MICHAEL	Middle L.	Last SMITH	4. DATE OF DEATH July	Month 17	Day 17	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 4, 1894	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY City Park Dept.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE SMITH				14. MOTHER'S MAIDEN NAME MARY LENTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I		17. INFORMANT Unknown		Address Hospital Records, VAH., Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.				INTERVAL BETWEEN ONSET AND DEATH 2 hours.			
(b) Generalized arteriosclerosis. DUE TO (c) Cerebral Arteriosclerosis.				10 years app.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.1				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p.	Month 19	Day 19	Year 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balto. Md.	(County) Balto. Md.
21. I certify that I attended the deceased from June 30, 1949, to July 17, 1957, and that death occurred at 6:24 A.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED M.D. V.A. Hospital, Perry Point, Md. 7-17-57							
ACTUAL SIGNATURE <i>W. Oppler</i>							
PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Director, Professional Services.							
22o. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF July 17, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer	22d. LOCATION (City, town, or county) Balto. Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE FINK FUNERAL HOME	ADDRESS Glen Burnie, Maryland.	24a. REC'D BY REGISTRAR July 17, 1957	24b. REGISTRAR'S SIGNATURE D. Daugherty	DATE			

CERTIFICATE OF DEATH

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
JUL 19 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07370
No. 54

Reg. Dist. No. 77

O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or removal.

VS. AISME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY Cecil			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE N.Y. b. COUNTY Queens		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East, R.D.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 64 St. Edward		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Sam	Middle Sonnenberg	Lost 7-28 1957	4. DATE OF DEATH Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-1910	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Appr. Navy Yd.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME David Sonnenberg					
14. MOTHER'S MAIDEN NAME Irene					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 068-09-6570		17. INFORMANT Address Brooklyn, N.Y. 4620 Fort HaM.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) lacerated left forearm. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car ran from east lane across west lane hit by bus			
20c. TIME OF INJURY 3:35 p.m.		Month, Day, Year 7 28 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40	20f. (City or town) North East, Cecil Ma.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7-29-57	
22a. BURIAL, CREMATION, OR BURIAL Removal		22b. DATE THEREOF 7-29-1957		22c. NAME OF CEMETERY OR CREMATORIAL Beth Israel	
22d. LOCATION (City, town, or county) Woodbridge, New Jersey					
(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Hennet					
ADDRESS North East, Maryland					
24a. REC'D BY REGISTRAR DATE 7-29-57					
24b. REGISTRAR'S SIGNATURE Sarah E. O'Farrell					

BUREAU V. S

NY 51 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07371
92

Reg. Dist. No.

07363

1. PLACE OF DEATH
a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Elkton

c. LENGTH OF STAY IN 1b

10 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Union Hospital. D.O.A.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

Md.

Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

21 Elkton

d. STREET ADDRESS

Main St.

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

7

15

1957

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR
Months Days

IF UNDER 24 HRS.
Hours Min.

M

W

WIDOWED

DIVORCED

7-17-1888

68 yrs.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Laboter

10b. KIND OF BUSINESS OR INDUSTRY

All kinds of work

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

no information

14. MOTHER'S MAIDEN NAME

No information

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

217-03-1141

17. INFORMANT

Mrs. Benny Bellowds. Elkton, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Acute Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

Hypertension and Ven. Failure

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year,
Hour
a. m.
p. m.

20d. INJURY OCCURRED
While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry and find that
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

R.G. Dodson

DATE SIGNED

EXAMINER'S
NAME (Type)

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

7-15-57

22a. FUNERAL CREMATION.
NO YES

22b. DATE THEREOF

JULY 18, 1957

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Catholic Cemetery

Mr. Chesapeake City Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

M. Henry Peppin Elstree, Md.

24a. REC'D BY REGISTRAR

DATE

7/18/57

24b. REGISTRAR'S SIGNATURE

F. F. Frazer

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Item 2 with the registrant's name, Item 3 should be used as a burial/transit permit. File Pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

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BUREAU V. S.

JUL 10 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE West Virginia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 2 mo. 11 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle E.	Last WELLING	
4. DATE OF DEATH	Month July	Day 26	Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Prison	11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Friend Welling		14. MOTHER'S MAIDEN NAME Frances Hayes		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 233-09-3929	17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid Carcinoma of left bronchus with 163X DUE TO metastasis to lymph nodes and the liver Conditions, if any, which gave rise to immediate cause (b) _____ DUE TO underlying cause (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 450.0 Arteriosclerosis, generalized, moderate.				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Unknown		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month VA	Day 19	Year 1957	
20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Moundsville	20f. (City or town) Moundsville	(County) West Virginia	(State) W. Va.
21. I certify that I attended the deceased from May 15 , 1957, to July 26 , 1957, W. Oppler , M.D., from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.				
DATE SIGNED W. Oppler				
ACTUAL SIGNATURE				
PHYSICIAN'S NAME (Type) W. OPPLER, M.D., Dir. Prof. Services, VAH, Perry Point, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 7-26-57	22c. NAME OF CEMETERY OR CREMATORIAL unknown	22d. LOCATION (City, town, or county) Moundsville, W. Va.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.	ADDRESS	24a. REC'D BY REGISTRAR Irene E. Daugherty	24b. REGISTRAR'S SIGNATURE Irene E. Daugherty	DATE 7-27-57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HAWAII - DEPARTMENT OF DEATH

DEPARTMENT OF DEATH

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JUL 30 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Reg. Dist. No.

(7385)

1. PLACE OF DEATH a. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leslie		c. LENGTH OF STAY IN 1b Visiting		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO North East, R.D.1		d. STREET ADDRESS /			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Ralph	Middle Ayres	Last Williams, 2nd	4. DATE OF DEATH 7	Month 7	Day 21	Year 1957	
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-23-1949	9. AGE (In years last birthday) 7 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School Boy		11. BIRTHPLACE (State or foreign country) North East, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ralph Ayres Williams, 1st.		14. MOTHER'S MAIDEN NAME Mary M. Hall							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Ralph A. Williams, North East, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8		Drowned		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped of diving board and missed inner tube and sank							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6.15 p. m. 7 21 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pond		20f. (City or town) Leslie		(County) Cecil	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7-22-57			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-1957		22c. NAME OF CEMETERY OR CREMATORIAL Methodist		22d. LOCATION (City, town, or county) North East Rd Cecil Md			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS Northeast Maryland		24a. REC'D BY REGISTRAR DATE 7-22-57		24b. REGISTRAR'S SIGNATURE Sarah E. Rothermel			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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REGISTRY
JUL 24 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)			
						a. STATE <u>MD.</u>			
						b. COUNTY <u>KENT</u>			
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GEORGETOWN, 14822</u>			
						d. STREET ADDRESS			
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>ANDREW</u>	Middle <u>W.</u>	Last <u>WILSON</u>	4. DATE OF DEATH	Month <u>JULY</u>	Day <u>21</u>	Year <u>1957</u>	
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 27 1878</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>0</u>	IF UNDER 24 HRS. Days <u>0</u>	Hours <u>0</u>	Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>JOHN F. WILSON</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE R. WOODDALL</u>		Address <u>GALENA, MD.</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>111-11-1111</u>		17. INFORMANT <u>JOHN F. WILSON</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u>		DUE TO <u>Cerebral Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acquired Nephrosis</u>		DUE TO <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>					
C (c) <u>Arteriosclerotic Kidneys</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X Generalized Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) <u>None</u> (County) <u>None</u> (State) <u>None</u>			
21. I certify that I attended the deceased from <u>June 21, 1955</u> to <u>July 21, 1957</u> , that I last saw the deceased alive on <u>July 21, 1957</u> , and that death occurred at <u>6 1/2 M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <u>None</u> DATE SIGNED <u>22 July 57</u>			
ACTUAL SIGNATURE <u>Wallace Oshenskin M.D.</u>									
PHYSICIAN'S NAME (Type) <u>Wallace Oshenskin M.D.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/23/57</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>GEORGETOWN CEM.</u>		22d. LOCATION (City, town, or county) <u>GEORGETOWN, MD.</u> (State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		ADDRESS <u>Millington, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 23 1957</u>		24b. REGISTRAR'S SIGNATURE <u>F. R. Frazee</u>			
VS A15 (4) 15M 9/55									

